

# A Call for Exploration of the Utilization of Structural Family Therapy with Adolescent Girls with Eating Disorders

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## Abstract

Eating disorders are extremely prevalent in the American society, particularly in the population of adolescent girls. Family dynamics have shown to have an effect on early development and symptom severity, identifying a necessity for early prevention and detection that can start in the home. In reviewing the literature, it has been found that treatment involving all family members can aid in symptom management of young girls who are struggling with eating disorders. This paper sheds light on the importance of implementing systemic treatment with adolescent girls. The purpose of this paper is to highlight the need for exploration of the utilization of structural family therapy (SFT) with this population. The authors recommend SFT to suit the varying needs of clients with an eating disorder and their overarching families.

**Keywords:** adolescents, eating disorders (ED), family therapy, girls, treatment

## 1. Eating Disorders

Eating Disorders (ED) are the persistent disturbances individuals experience in their eating habits or food consumption (APA, 2013). Eating disorders are one of the most common chronic illness among adolescent females (Kalisvaart & Hergenroeder, 2007). In fact, it has been documented that over 30 million Americans suffer from an eating disorder (Le Grange, Swanson, Crow, & Merikangas, 2012). It has previously been reported that nearly one in five Americans claim to have some form of disordered eating behavior (National Institute of Mental Health's Guide, 2011).

When paired with comorbid mental illness, eating disorders have significant negative physical and psychological outcomes (APA, 2013). The rising pervasiveness is matched by expensive personal costs for mental health and medical services, reported to be over \$100,000 dollars a year or about \$300 a day (ED Coalition, 2014). This increased salience within public healthcare additionally indicates that continued research into innovative treatment strategies and interventions are an important part of improving symptom management and overall patient recovery.

In order to understand the risk factors that can increase likelihood of developing an ED it is necessary to have a basic understanding of the different type of EDs. The main categories of EDs most documented and studied are anorexia (AN), bulimia nervosa (BN), and binge eating disorder (BED). While these disorders are characterized by different disordered eating habits, there tends to be similar circumstances in which they develop.

An increased prevalence of EDs within the United States necessitates comprehensive, evidence-based treatment. The purpose of this paper is to highlight the need for exploration of the utilization of structural family therapy (SFT) with this population. With the onset of disordered eating habits appearing as early as adolescence it can be speculated that the role of family dynamics, particularly, parenting style and home environment /family structure may have an effect on development of EDs. These topics will be discussed further to display the need for a family-based approach.

### 1.1 Anorexia

Anorexia (AN) is characterized by restrictive eating habits, body dysmorphia, and fear of gaining weight (APA, 2013). A quantitative indicator of this disorder is low BMI; body mass index, calculated based on an individual's height and weight, can lead to a diagnosis of AN. When experienced consecutively with a marked decrease in consumption of an adequate, balanced diet, the physiological effects of this type of ED are nearly unavoidable. Past studies reveal that young women struggling with AN are twelve times more likely to pass away when compared to other girls their age (Sullivan, 1995).

### *1.2 Bulimia Nervosa*

Bulimia nervosa (BN), another prominent ED, is distinguished by cyclic patterns of bingeing and purging (APA, 2013). Bingeing occurs when an individual exhibits excessive consumption in a short period of time, typically ending when the individual runs out of food, experiences stomach pain, or is interrupted in some other way (National Institute of Mental Health, 2011). Following this initial stage in the behavioral pathway, an individual will choose a way to purge through laxative use, fasting, diuretics, excessive exercising, or self-induced vomiting (APA, 2013). The act of purging is motivated by personal desire to not gain weight and from the guilt induced by bingeing. Body weight for clients with BN is normal for development, and this creates an inherent barrier in both recognizing and diagnosing the condition, especially in comparison to AN. For diagnostic criteria to be met, an individual must partake in a binge-purge episode once per week for three months and undergo critical body evaluation (APA, 2013).

### *1.3 Binge Eating Disorder*

Binge-Eating Disorder (BED) occurs when an individual partakes in a binge that is not followed by the act of purging (APA, 2013). The binge can take place in private or public and is characterized by a person eating past the point of being full (APA, 2013). BED is likely to be caused by stress with exorbitant eating used as a form of emotional regulation; however, feelings of guilt are immediate consequences of this maladaptive coping mechanism (APA, 2013). Much like bulimia nervosa, binges need to take place one time per week for three months to be considered as diagnostic criteria for BED. An overlap in development and estimated age of onset are present across these three most prevalent EDs, with adolescent females most likely to be diagnosed and presenting earlier signs of mental and physiological distress when compared to other demographics (APA, 2013).

## **2. Development of Eating Disorders in Adolescents**

At the center of attention for clinicians and researchers has been AN and BN defined by disturbance in eating habits that may be either excessive or insufficient food intake. Moreover, BN, AN, and BED are the most common forms of EDs based on the diagnostic and statistical manual of mental disorders (DSM) believing to arise from the interaction of multiple risk factors (Rikani, Choudhry, Choudhry, Ikram, Asghar, Kajal, & ... Mobassarrah, 2013).

Adolescence is a significant time where an individual may feel an abundance of peer-pressure to locate themselves in a world full of perplexities, all while experiencing many changes in and around them (Neumark-Sztainer, Bauer, Friend, Hannan, Story, & Berge, 2010). The adolescent years can be stressful and cause anxiety due to the many ongoing physical and emotional changes. EDs are usually a result of various psychological, biological, personal, social, and environmental factors placing adolescents as the most high-risk group of people in developing an ED. Adolescence is a period heightened by body image concerns and peer pressure which can be risk factors in the potential development of an ED (Neumark-Sztainer et al., 2010). Feelings of self-consciousness, low self-esteem and comparison with peers interwoven with the physical transformation taking place during adolescence EDs become a coping mechanism when feeling helpless in other aspects of their life. Peers, parents, and the media are hypothesized sociocultural agents thought to contribute to the development of ED attitudes and behaviors as well as the potent messages regarding the need to imitate the societal paradigm of thinness. The development of body image and disordered eating are affected by these influences due to the societal messages being reinforced regarding the importance of thinness. EDs are most likely to emerge during late adolescence indicated by longitudinal studies, suggesting that it is worth investigating this critical period and the role peer and parental influences play (Linville, Stice, & Gau, 2011).

## **3. Role of Families in Eating Disorders**

### *3.1 Parenting*

The impact of parental influence and messages directed toward adolescents, especially female adolescents, play an etiological role in the development of EDs. Mothers who encourage their daughter's weight loss through negative commentary are correlated with disordered eating and the drive for thinness among young adolescents (Linville et al., 2011). A fear of weight gain, a chaotic eating style, and a preoccupation with body shape adversely affect parents who have EDs and their ability to care for and nurture their child. Eating psychopathology has been related to serious parenting difficulties and mothers with ED symptoms may implement greater control in their feeding interactions with children (Haycraft & Blissett, 2010).

For children to become well-adjusted adults, research shows that parents are to play a key role in maximizing self-efficacy, cognitive, personal, and emotional development and minimizing problem behaviors. Body satisfaction, physical activity, and children's dietary practices are influenced through control of food socialization practices and through their food-related parenting style. A crucial socio-cultural component in the development of EDs is the home environment and the parent-child relationship being the highest importance in the prevention of disordered eating (Enten & Golan, 2009).

In a study that examined associations between ED symptoms and parenting style the findings reported correlations that

higher levels of drive for thinness were related to more permissive and authoritarian parenting styles (Haycraft & Blissett, 2010). Body dissatisfaction was found to be linked to a permissive parenting style, and symptoms of BN were associated with a more authoritarian parenting style (Haycraft & Blissett, 2010). Parenting styles are classified into three distinctive styles characterized by varying degrees of control and parental warmth are parents who are authoritarian, authoritative, and permissive (Baumrind, 1971; Haycraft & Blissett, 2010). Permissive parents are inclined to be overly indulgent or neglectful and impose little control. Authoritarian parents are characterized by being demanding and overly controlling and are often emotionally unresponsive. Authoritative parents impose clear demands in conjunction with warmth, emotional responsiveness, and autonomy granting. Permissive and authoritarian parenting have been associated with less than optimal outcomes compared to the authoritative parenting style which fosters optimal child development (Baumrind, 1971; Haycraft & Blissett, 2010).

A study conducted by McEwen and Flouri (2009) which investigated the role of emotional regulation in the relation between fathers' parenting (behavioral control, psychological control, and warmth) and adolescents' emotional and ED symptoms it was determined that fathers' parenting directly and independently contributed to adolescents' ED symptoms. Another study noted, that when a father's parenting style was perceived to be neglectful, the style mainly concerned in the specific ED symptoms as drive for thinness, BN, and body dissatisfaction patients scored highest in BN and body dissatisfaction displaying that low parental care is related to body image concerns and weight phobia (Lobera, Rios, Casals, 2011).

Parenting styles play a significant role in EDs and the role of the family has etiological factors as well, due to weight being a sensitive issue and parents finding challenges discussing their child's weight. Parents may lack the knowledge and understanding to know *if* and *how* it is appropriate to discuss weight related topics with their child as well as letting their own beliefs on eating and weight influence their child's beliefs (Neumark-Sztainer et al., 2010). Family cultures comprised of ideologies in being appearance-focused have emerged as a contributing factor in disordered eating in daughters. When it was shown that mothers were appearance-focused it was established that females developed unhealthy eating behaviors in comparison to their peers (Fortesa & Ajete, 2014). Parental comments that led to encouragement to diet have been found to be predictive of weight gain and unhealthy weight control behaviors. Moreover, family attitudes toward appearance were determined to be the strongest predictor in problematic weight-related outcomes (Fortesa & Ajete, 2014).

### 3.2 Family Context

An important influence on weight-related outcomes in children are the family environment and home. Neumark-Sztainer et al. (2010) studied family weight-teasing, parent dieting, and weight-related problems in the homes of adolescent girls to examine associations between these family variables and girls' weight status, body satisfaction, and disordered eating behaviors. The study reported that approximately two-thirds of the girls reported that their mother talked about her own weight or dieted, and nearly half of the girls stated that their mother encouraged them to diet. Approximately 40% of the girls recounted that their father talked about his weight, dieted, and encouraged them to diet (Neumark-Sztainer et al., 2010). Moreover, about 60% of the girls reported they experienced some level of weight-teasing by family members over the past year, which was significantly associated with unhealthy and extreme weight control behaviors, binge eating, and higher levels of body dissatisfaction (Neumark-Sztainer et al., 2010).

Appearance-focused family culture and weight-related teasing and comments have emerged as a contributing factor in disordered eating in daughters. It has been hypothesized that social reinforcement such as encouragement to dieting, family modeling of disordered eating behaviors, and criticism regarding weight fosters and propagates the thin ideal of body image, resulting in eating pathology. Negative comments about appearance and blatantly positive feedback may lead to negative consequences and unhealthy weight control behaviors and weight gain. Research findings revealed that parental comments predicted disordered eating and comments when given with positive intentions, can still have a negative impact on daughters (Fortesa & Ajete, 2014).

When children are exposed to unhealthy and problematic environments adolescents are negatively impacted. ~~and~~ Research demonstrates that marital conflict also plays a role in unhealthy eating, disordered eating, weight related behaviors such as drive for thinness, food restriction, dieting, bingeing, and purging (Blodgett-Salafia, Schaefer, & Haugen, 2013). Marital conflict may contribute to maladjustment in adolescents and is strongly associated with externalizing and internalizing behaviors, anxiety, depression, impaired social relationships, conduct problems and poor academic success leading researchers to focus more on disordered eating being a negative outcome associated with marital conflict (Blodgett-Salafia et al., 2013). Marital conflict was found to be indirectly and directly, via poor mother-and father-adolescent relationship quality, associated with disordered eating in girls suggesting that mother-father, mother-adolescent, and father-adolescent family subsystems can play a part in influencing eating patterns (Blodgett-Salafia et al., 2013).

In a study involving marital conflict and disordered eating as it relates to emotional insecurity, it was found that children who experience the stress of being in a family with marital conflict places children at a greater risk for developing ED (Bi, Haak, Gilbert, & Keller, 2017). Marital conflict is one of the most significant stressors that children can face, which influences the maladaptive patterns of disordered eating. Furthermore, marital conflict was found to be linked to greater child emotional insecurity about the family, which was associated with greater anxiety in children, which then related to disordered eating (Bi et al., 2017).

Gillett, Harper, Larson, Berrett, & Hardman (2009) compared implicit family rules in families with a daughter who has been diagnosed with an eating disorder, anorexia, bulimia or eating disorder not otherwise specified (EDNOS) and families with a daughter who does not have an eating disorder. This purpose was to see if there is a correlation between family rules and the presence of an eating disorder. "In this study, family rules were defined as implicit, unwritten family norms formed as a result of redundant interactions that govern family members' behaviors. Such rules either facilitate or inhibit communication, understanding, openness, growth, and connection within the family" (Gillett et al., 2009, p. 160). It was found that families that had a daughter receiving inpatient treatment reported having higher levels of facilitative family rules for kindness, expressiveness, and connection than families with a daughter receiving outpatient treatment.

#### **4. Eating Disorder Treatment**

Unfortunately, adolescents with an eating disorder do not frequently receive treatment. In fact, less than 1 in 5 adolescents with an eating disorder are treated (Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). These numbers are even smaller when considering family treatments. This is particularly interesting since the development of EDs in adolescent girls is primarily intertwined with the family, thus, it is typical that a therapist must consider familial influence in providing treatment.

In treating an ED, a therapist must view clients from a threefold perspective that incorporates their physical and mental health pertaining to the condition, as well as any present comorbidities. In accounting for comorbidity, EDs have significant negative physical and psychological outcomes (APA, 2013). Nearly 50% of those suffering from ED have a related affective disorder, while 30% deal with a co-occurring anxiety disorder (Lock, 2015). Further emphasizing that all of a client's mental health aspects must be considered when preparing a treatment plan.

Eisler, Dare, Hodes, Russell, Dodge, and Le Grange (2000) sought out to find the difference in treatment outcomes between conjoint family therapy and separated family therapy. Conjoint family therapy is considered to be when the therapy sessions involve the whole family and separated family therapy is when the parents and the identified patient are seen separately by the therapist. Researchers had clients complete several different assessments: for mood (Short Mood and Feeling Questionnaire), self-esteem (Rosenberg Self Esteem Inventory), obsessional phenomena (Maudsley Obsessional Compulsive Index), and two inventories targeting eating disorders (Eating Aptitude Test and Eating Disorder Inventory). Family members completed the Family Adaptability and Cohesion Evaluation Scales (FACES III) which is used to assess perception of closeness and rigidity. Researchers observed a reduction in levels of criticism from parent to adolescent which aided in displaying improvement and efficacy from the different therapeutic interventions. Both groups, regardless of type of family therapy, displayed progress throughout the course of treatment. What is specifically important to highlight is that in both groups, family is involved in the overall treatment process.

#### **5. Structural Family Therapy and Eating Disorders**

Salvador Minuchin, the founder of SFT, aimed to alter dysfunctional hierarchies and boundaries to allow for healthy hierarchies and clear boundaries (Tadros & Finney, 2018). Normal family development consists of a family structure that is adaptive and flexible (Minuchin & Fishman, 1981). In addition, normal family development must possess clear boundaries and a hierarchy (Minuchin & Fishman, 1981).

In SFT, lack of structure is what leads to dysfunctional familial patterns. In a family system, maintained problems are attributed to the dysfunction in a family's structure in terms hierarchy and unhealthy boundaries (Finney & Tadros, 2018). Rigid boundaries are those that are restrictive with limited contact within and outside the family system (Minuchin, 1974). Boundaries that are too rigid may lead to disengagement. Alternatively, diffuse boundaries are less restrictive and much more open, allowing communication within and outside the family system. Too diffuse of boundaries may lead to enmeshment. Dysfunctional patterns or symptoms may occur when a family is operating from either end of the continuum (rigid or diffuse) (Minuchin, 1974). It has been postulated that AN can only be developed in a specific context in which a family's boundaries may be too rigid or diffuse (Minuchin & Fishman, 1981).

This strength-based model highlights the constant transformative nature of the family and how familial hierarchy can contribute to unhealthy behavioral patterns (Tadros & Finney, 2018). In the context of EDs, initial steps toward improving symptomatology through SFT's principles and techniques include empowering parents to be placed on the top of

the hierarchy which may lead to acting as the director of family feeding habits. Additionally, creating and maintaining healthy, clear boundaries which allow for developing a strategy to help the client obtain a health body image as well as weight. Overall, it is vital to provide psychoeducation to all family members rather than include simply the deemed identified patient. This allows for fostering a unified approach to not only support the adolescent with an eating disorder, but additionally, to look through a systemic lens to treat the family as a relational unit.

## 6. Clinical Implications

The reviewed literature depicts how parenting styles, marital conflict, and family cultural values tie into the developmental and sustained nature of adolescent EDs. Individual and group psychotherapy has been researched in the treating of various types of EDs. There are articles citing the successful outcomes of treatment in utilizing different theoretical conceptualizations. The authors do not aim to discredit or diminish the favorable results achieved through such methodologies. Instead, the authors call for attention to factors that more individualized treatments do not seem to focus on. Thus, a relational approach is encouraged to provide comprehensive treatment in order to provide support as well as to account for contextual and relational factors.

This paper highlights the role of family in EDs as well as the utilization of SFT as a form of treatment. This paper introduces that SFT is the optimal treatment modality due to its focus on structure, roles, rules, and boundaries. Seeing as it is clear that family factors are a risk factor for development of EDs it is clear that family should be involved in the treatment of adolescent females. The authors acknowledge there are no found clinical case studies that specifically evaluate effectiveness of SFT and eating disorders. Thus, speaking to the imminent need to further research this systemic theory and the complex familial issues that arise when a member of the family is suffering from an eating disorder.

Adding to the body of research pertaining to family therapy is necessary in determining holistic ways of treating mental and physical illness. ED is considered to be a chronic and potentially fatal disorder, therefore, there is a dire need to examine what treatments best help combat symptomatology and how to cater to clients who could benefit from additional treatments. Additionally, in accordance with multicultural considerations, it is vital to work under the cultural rules and roles of the specific family being treated (Tadros, 2018). When working with families of different cultural values it is recommended that “techniques and interventions used in treatment for individuals and families should derive from previous knowledge and cultural observation from the viewpoint of the client(s)” (Marbley, Wimberly, Berg, Rouson, & Wilkins, 2011, Tadros, 2018, p.45).

## 7. Future Research Directions

There are inherent challenges in treatments related to EDs. Generally, especially with family therapy, it is extremely hard to specifically identify and quantitatively measure a family’s culture. The attitudes and beliefs of a family are prone to impact the development of the adolescent. The difficulty therein lies with how a family determines what their culture is and in what ways researchers can operationalize this information for inter-sample comparison. Despite these challenges, there is a need for further examination in clinical case studies that will add to the understanding SFT and its benefits for individuals with an ED.

Incorporating a feminist and/ or multicultural perspective to future reviews of literature and experimental studies may be helpful in including more diverse sampling populations to account for gaps in the research. Few studies take into account the male populations struggling with EDs. The dearth in literature involving adolescent males makes it difficult to speculate how a family unit can affect the development of EDs and the benefit that family therapy can have. Incorporating a feminist and/ or multicultural approach will also take into consideration the contemporary fluidity of gender roles in American society. For example, fathers are now playing more of a nurturing, guiding part in the early childhood and adolescent development of young girls. Conducting research in how gender and parenting styles affect the potential for development of disordered eating is a specific directional suggestion for future research.

In addition to parental figures effecting development of EDs there is also more pressure from society to conform to the “thin ideal” which is having a greater effect on both males and females. This can be seen through popular social media outlets and role models that adolescents idealize. Further research can be done on how confronting the “thin ideal” can be helpful in the family setting in order to create a more supportive environment for adolescents who are currently struggling with disordered eating habits. Seeing as the “thin ideal” is becoming more prevalent in modern society, one can assume that EDs will continue to be prevalent within the mental health field.

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